Argonne NATIONAL LABORATORY

BLUE CROSS BLUE SHIELD OF ILLINOIS (BCBSIL)
2013 COMPREHENSIVE BENEFIT PLAN SUMMARY

Benefit	BCBS Comprehensive Medical Plan
Deductible, Co-Insurance Out-of-Pocket Maximum	$300 individual annual deductible ($600 family), then plan pays 80% of eligible charge. Calendar year out-of-pocket limit of $2250 for single, $4500 for retiree + 1, and $6750 for family ($2250 for up to 3 family members) plus deductible, then plan pays 100% of eligible charge for the remainder of the calendar year.
General Hospital Admission	Inpatient covered services at 80% of eligible charge after deductible.
In-Hospital Services, Supplies, and Anesthesiology	80% of eligible charge after deductible.
Out-Patient and In-patient Surgery	80% of eligible charge after deductible.
Out-Patient X-Ray and Laboratory	80% of eligible charge after deductible.
Emergency Care	80% of eligible charge after deductible.
Physicians Visits: In-Hospital, Office Visits, Consultations	80% of eligible charge after deductible.
Routine Annual Physicals, Immunizations and Tests are not covered unless specifically listed below: - Well Child Care under Age 3 and Immunizations - Preventive Care Woman-Exam, Pap and mammogram - Preventive Care Man-Exam with PSA Test - Colorectal Cancer Screening	80% of eligible charge after deductible. Does not include tests other than pap, mammogram, PSA with preventive care exams. Fecal occult blood test based on cancer screening guidelines. Any other tests must be performed for medical diagnosis of a medical condition and not just for routine screening. **Note: Immunizations only covered for children under age 3.**
Home Health Care	80% of eligible charge up to 40 days per calendar year.
Skilled Nursing Facility	80% of eligible charge up to 60 days in a calendar year.
Hospice Care	80% of eligible charge.

Note: Coordination of Benefits with Medicare or other health care plan is up to the Argonne health care plan allowed amount.

COMPREHENSIVE BENEFIT PLAN SUMMARY (CONTINUED)

Benefit	BCBS Comprehensive Plan
Mental Health and Substance Abuse Care	80% of eligible charge after deductible.
Pre-Authorization Requirement	Pre-authorization required prior to hospitalization **unless another insurer is primary, such as Medicare**. Notification must be made within 48 hours of emergency admission. Case management is available for serious conditions.
Prescription Drug Plan *Co-insurance maximums separate from Medical and Dental Plans.*	No deductible for prescription drugs. Annual out-of-pocket maximum for 30-day retail drugs $1500/person, $3000/ family. The annual out-of-pocket maximum does not apply to Retail 90 or Mail Order. **Retail 30 day supply:** **Generic**: 20% (minimum $10) **Brand:** 25% (minimum $20) **Retail 90 day supply:** **Generic:** $25 **Brand:** $55 **Mail Order 90 day supply:** **Generic**: $20 **Brand:** $50 **Specialty Drugs:** $20% with separate maximum of $1000/person, $2000/family. **When generic drug is available, participant must use generic or pay cost difference along with brand co-pay for both retail and mail order.**
Delta Dental PPO Dental Plan *Deductible and co-insurance maximums separate from Medical and Prescription Drug Plans.* In-network includes PPO or Premier. PPO provider accepts discounted rates and Premier provider agrees not to charge over allowed amount.	$100 individual annual deductible, $300 family; plan pays 75%, patient 25% for dental work. Diagnostic and preventive services paid at 100% of contracted rate each calendar year include 2 cleanings and exams, 2 bite-wing x-rays, 1 fluoride treatment. 1 complete full mouth x-ray allowed in 36 month interval. Calendar year maximum per person $2000. Orthodontic lifetime maximum per person $2000.

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